MARYLAND STATEWIDE HEALTH REFORM DEMONSTRATION

FACT SHEET

Name of Section 1115 Demonstration:	HealthChoice
Date Proposal Submitted:	May 3, 1996
Date Approved:	October 30, 1996
Implementation:	June 2, 1997
Date Authority Expires:	June 1, 2002
Date Extension Proposal Submitted:	June 1, 2001
Date Extension Proposal Approved:	November 27, 2001
Date Extension Proposal Expires:	May 31, 2005

The Centers for Medicare & Medicaid has approved a three year extension of the State of Maryland's section 1115 demonstration entitled HealthChoice**.**. The driving forces behind the demonstration are the rapidly rising costs of Medicaid and the poor coordination of care in the current program for the sickest, most costly beneficiaries. The program has been developed on the basis of several guiding principles: provide a patient-focused system with a medical home for all beneficiaries; build on the strengths of the current Maryland health care system; provide comprehensive, prevention-orientated systems of care; hold Managed Care Organizations (MCOs) accountable for high quality care; and achieve better value and predictability for State expenditures. Under the HealthChoice program, a statewide health care reform program, the State enrolls demonstration eligibles into a MCO or the Rare and Expensive Case Management (REM) system. Mental health services are provided under the demonstration in a separate fee-for-service delivery system.

ELIGIBILITY

- Initial enrollment in HealthChoice began on June 2, 1997, and continued through November 1997. Enrollment for new members will continue throughout the demonstration. As of February 2002, there were 434,983 beneficiaries enrolled in the program.

- Since the Maryland Children's Maryland's Children's Health Insurance Program (CHIP) was implemented on July 1, 1999, the State has enrolled 96,225 CHIP eligibles into the HealthChoice program. As of February 2002, there were 3,096 beneficiaries enrolled in the REM program.

- On July 30, 2002, the State received approval to provide Medicaid payment to two groups of people not currently eligible for Medicaid, CHIP, or Rx coverage under the State's Medical Assistance/Health Choice Program. The first group consists of individuals whose income and asset standards are below 116% of the federal poverty level and includes all Qualified Medicare Beneficiaries (QMBs). The second group consists of individuals whose income and asset standards are below 175% of the federal poverty level and does not include QMBs. It anticipates approximately 90,000 individuals participating in its pharmacy program. These individuals will only receive the pharmacy benefit under the demonstration.

  The following categories will be excluded from the demonstration and will continue to receive benefits under the traditional Medicaid program: Dual eligibles (except for the pharmacy benefit), including Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries; short-term eligibles in a spend-down status; institutionalized individuals; children in the Model Waiver; individuals in the Home and Community-Based Services Waiver for Senior Assisted Housing Residents; and women in the Family Planning Waiver Program.

  There is a six-month guaranteed eligibility period for beneficiaries under the demonstration. Further, presumptive eligibility for a pregnant woman has been replaced by a procedure for simplified eligibility, administrated at the Local Health Department, for individuals in the Pregnant Woman and Children's (PWC) Program and guaranteed eligibility for all pregnant women through two months after delivery. The current policy of providing retroactive eligibility to Medicaid recipients continues under the demonstration.

BENEFIT PACKAGE

Under the demonstration, beneficiaries will be entitled to receive all of the benefits that were provided under the Maryland Medical Assistance program prior to implementation with the exception a limited number of carve-out services that will be paid for directly by the State on a fee-for-services basis. The carve-out services include: personal care and medical day care services; services provided to children under an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP); Healthy Start case management services; and transportation services. Effective November 2, 1999, outpatient rehabilitation services for children under 21 years old, including medically necessary and appropriate physical therapy, occupational therapy, speech therapy and audiology services were removed from the MCO benefit package. These are now directly reimbursed by the State on a fee-for-service basis.

With the exception of specialty mental health services and ill which will be provided by MCOs but reimbursed on a fee-for-service basis, the MCOs will be responsible for providing the full array of services under a prepaid, risk contract. In addition, MCOs will be financially responsible for self-referral by beneficiaries for: family planning services from alternative providers; school-based clinic services; pregnancy related services; the initial medical exam for children under State custody; and annual visit to the Diagnostic and Evaluation Unit for individuals diagnosed with HIV/AIDS; renal dialysis; and OB/GYN care provided to pregnant woman already receiving prenatal care.

Individuals in the REM program will receive extensive case management services in addition to all of the services provided under the demonstration.

Specialty mental health services will be provided, and funded, through a separate system administered by the Mental Hygiene Administration (MHA) in conjunction with local Core Service Agencies (CSAs) which will in-turn contract with mental health care providers and a competitively-procured administrative service organization, Maryland Health Partners (MHP) that will assist with administration and monitoring of the specialty mental health system.

Under the recently approved pharmacy amendment, the expansion population in both groups will have access to all Medicaid formulary drugs. The State will directly administer this program. These individuals will only receive the pharmacy benefit under the demonstration.

ENROLLMENT/ DISENROLLMENT PROCESS

An enrollment agent, Benova, is responsible for assisting beneficiaries in their selection of a MCO. MCOs are not permitted to conduct direct marketing or enrollment activities. Beneficiaries have 21 days to select a MCO from the day the State mails an eligibility notification. Individuals who do not make a choice will be assigned to a MCO by the State.

Beneficiaries will have a 12-month lock-in with one opportunity in the first year to change plans without cause, and the opportunity to change plans annually and for good cause in subsequent years.

Individuals can access the specialty mental health component of the demonstration either through: A referral from their MCO, the toll-free hot line, or direct contact with MHP, a CSA, or participating provider.

DELIVERY SYSTEM

The State anticipates that approximately 99 percent of the waiver eligible population will be enrolled in an MCO. The term "MCO" incorporates traditional HMOs and newly formed entities that are certified for participation in the demonstration for the exclusive purpose of providing care to Medicaid recipients. These new entities consist of community-based providers (Federally Qualified Health Centers (FQHC); Maryland Qualified Health Centers (MQHCs), etc.) and institution-led networks. All types of organizations must meet the same standards relating to quality, access, and data in order to qualify as an MCO.

The State will contract with any organization that can comply with the terms of the regulations (which include the quality, access, and data standards) and agrees to accept the established capitation rates. Further, in order to preserve the safety-net system that exists within the current program, the State will assure that each historic provider (essentially any provider who has served the Medicaid population prior to implementation of the demonstration), who meets the standards established in the regulations, is offered a contract with at least one MCO.

The REM component of the demonstration will consist of a network of specialized providers who are reimbursed on a fee-for-service basis.

Specialty mental health services will be provided, and funded, through a separate system administered by the Mental Hygiene Administration (MHA) in conjunction with local Core Service Agencies (CSAs) which will in-turn contract with mental health care providers and the competitively-procured MHP that will assist with administration and monitoring of the specialty mental health system.

QUALITY ASSURANCE

The State has instituted an extensive quality assurance program that consists of such components as: access and quality standards; utilization and outcome measures with an emphasis on special needs populations; encounter data reporting requirements; beneficiary and provider satisfaction surveys; and a grievance and appeals process. The program follows the Health Care Quality Improvement System (HCQIS) guidelines and utilizes Medicaid HEDIS outcome measures. Further, the State will monitor compliance to the requirements and publish a report card on each MCO's performance for beneficiaries to use when selecting plans.

COST-SHARING

The demonstration does not involve the implementation of co-payments, premiums, or deductibles except under the pharmacy expansion. Under that pharmacy program, individuals whose income and asset standards are below 116% of the federal poverty level (including QMBs) receive Medicaid Rx formulary drugs for a $5.00 co-payment. Individuals whose income and asset standards are below 175% of the federal poverty level receive Medicaid Rx formulary drugs by paying a 65% co-insurance rate plus a $1.00 processing fee.

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